



ADMINISTER

Norflex[®] INJECTABLE,

intramuscularly or intravenously;
in minutes the dose of only 2 cc
*resolves the spasm and relieves the
pain.*

THEN PRESCRIBE

Norflex[®] TABLETS;

just 2 tablets a day *sustain the
relief and restore mobility.*

"NORFLEX" INJECTABLE — FOR INTRAVENOUS OR INTRAMUSCULAR USE is an aqueous isotonic solution of the potent skeletal muscle relaxant, orphenadrine citrate (2-dimethylaminoethyl 2-methylbenzhydrol ether citrate). It is the orthomethyl analogue of diphenhydramine.

FORMULA

| | per two (2) cc |
|----------------------------------|----------------|
| Orphenadrine citrate* | 60.0 mg |
| Sodium bisulfite | 2.0 mg |
| Sodium chloride | 5.8 mg |
| Water for Injection, U.S.P. q.s. | 2.0 cc |
| Sodium hydroxide | to pH 6.0 |

INDICATIONS

For rapid relief of skeletal muscle spasm and associated pain, regardless of location.

ADMINISTRATION

Average adult dose: 1 ampul—2 cc (60 mg) intravenously or intramuscularly. May be repeated every 12 hours. Relief may be maintained by 1 "NORFLEX" tablet twice daily.

CONTRAINDICATIONS

There are no known contraindications.

SIDE ACTIONS

Infrequent at the recommended dosage. Those encountered are: dizziness, drowsiness, dryness of the mouth, slight blurring of the vision, nausea, skin rash and restlessness. These symptoms disappear rapidly with a reduction in the dosage or cessation of medication.

WARNING

Some patients may experience transient episodes of light-headedness or dizziness following injections of "NORFLEX" INJECTABLE. Mild anticholinergic activity of "NORFLEX" suggests it should be used with caution in patients with glaucoma, tachycardia and urinary retention.

AVAILABILITY

Boxes of 6 ampuls and 50 ampuls.

CAUTION

Federal law prohibits dispensing without prescription.



RIKER LABORATORIES, INC.
NORTHRIDGE, CALIFORNIA

* PATENT NOS. 2,567,351; 2,991,225

Let "Mature" Child Make Own Decisions

Letting a child make his own decisions will train him to become a well disciplined adult.

This is the advice of Dr. Frank Howard Richardson, Black Mountain, N. C., author and former consultant, New York Department of Health, writing in the February *Today's Health* magazine, published by the American Medical Association.

When the parents are convinced that the child is mature enough to act sensibly, he should be permitted to make his own decisions, Dr. Richardson said, and this point is reached earlier than is usually realized.

It is "most important" that adolescents make their own decisions, he said. Although the adolescent knows he is dependent upon his parents, he said, the youngster wants to direct his own life.

Points of difference between the parents and child should be discussed frankly and freely, he said, and the parents must be open-minded.

"If his decision does not seem reasonable to the parents' mature judgment, it is their duty to veto it, tactfully but very firmly," Dr. Richardson said. "For as long as they are supporting him and are legally as well as morally responsible for his action, it is their say-so, not his, that must be the decisive verdict."

Such a policy is not easy to administer, but it is so much more satisfying to both parents and young people that it is well worth the necessary effort, he said, adding:

"For they [the children] will have learned to make decisions. But they will have learned as well that their decisions are always subject to some higher court.

"The well disciplined adult is never absolutely free to make decisions. But he has learned to make most of his decisions wisely."

SLIDE MARKING TECHNIQUE TO FACILITATE REEXAMINATION OF SIGNIFICANT CELLS—T. A. Treanor. *Amer. J. Clin. Path.*—Vol. 36:567 (Dec.) 1961.

A simple, accurate method of marking significant cells, using a silver drawing or blueprint marking pencil, is presented. This technique is particularly useful when screening Papanicolaou smears.

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CORRECTIVE SURGERY FOR TETRALOGY OF FALLOT—E. B. Kay, C. Nogueira, D. Mendelsohn, Jr., and H. A. Zimmerman. *Circulation*—Vol. 24:1342 (Dec.) 1961.

Fifty patients with tetralogy of Fallot had surgical correction of defects by open technique during the past five years with better results than by the previous techniques. The previous overall mortality of 18 per cent was reduced to 15 per cent during the past two years. Forty-one patients are alive, asymptomatic, and with normal physical activity. Complete cardiac catheterization studies were made preoperatively, and from one to three years postoperatively on 15. Thirteen had normal hemodynamics following correction, and two had marked clinical improvement but evidence of small residual shunt.